Test Data for §170.314(f)(5) Cancer case information – ambulatory setting only

Reference the test procedure for test data implementation.

TD170.314(f)(5) Cancer Case Information – Data Set # 1

Electronically Record Cancer Case Information

A user records three instances of cancer case information for the test patient(s).

**Record Instance 1:**
Digital rectal exam: Nodular, hard prostate noted  
PSA Score: 7  
Sextant biopsy: Adenocarcinoma, Grade 1, in 1 of 6 core biopsies  
Diagnosis: Adenocarcinoma of Prostate

**Record Instance 2:**
Physical exam: Within normal limits, no swelling, soreness, or enlargement  
Diagnostic tests: Blood smear and bone marrow aspiration  
Diagnosis: Indolent Chronic Lymphocytic Leukemia

**Record Instance 3:**
Physical exam: Irregularly shaped, 3 cm ulcerated pigmented lesion located on left upper back and enlarged axillary lymph nodes  
Chest x-ray: Irregular mass in the left upper lobe of the lung  
Diagnosis: Malignant melanoma with possible metastasis to lymph nodes and the lung

Electronically Change Cancer Case Information

A user changes the three instances of cancer case information recorded for the test patient(s).

**Change Instance 1:** Mark words as error and enter replacement words.  
*Strike-through is used only to indicate to the Tester and Vendor which words are error and does not prescribe how the EHR is to mark the words as error*  
Digital rectal exam: Nodular, hard, Normal prostate noted  
PSA Score: 7  
**Sextant Biopsy: Adenocarcinoma, Grade 1, in 1 of 6 core biopsies**  
Diagnosis: Adenocarcinoma of Normal Prostate, no evidence of Adenocarcinoma
Change Instance 2: Add words to the Information
Physical exam: Within normal limits, no swelling, soreness, or enlargement
Reported symptoms: Continuous fatigue, weight loss
Diagnostic tests: Blood smear and bone marrow aspiration
Diagnosis: Indolent Chronic Lymphocytic Leukemia

Change Instance 3: Cancer case information was entered into the wrong patient’s record. Mark all information as entered in error.
(Strikethrough is used only to indicate to the Tester and Vendor that the entire note is to be marked as error and does not prescribe how the EHR is to mark the note as error)
Physical Exam: Irregularly shaped, 3 cm ulcerated pigmented lesion located on left upper back and enlarged axillary lymph nodes
Chest x-ray: Irregular mass in the left upper lobe of the lung
Diagnosis: Malignant melanoma with possible metastasis to lymph nodes and the lung

Electronically Access Cancer Case Information
A user accesses and displays the three instances of cancer case information that were recorded and changed.

Access Instance 1:
Digital rectal exam: Normal prostate noted
PSA Score: 2
Diagnosis: Normal Prostate, no evidence of Adenocarcinoma

Access Instance 2:
Physical exam: Within normal limits, no swelling, soreness, or enlargement
Reported symptoms: Continuous fatigue, weight loss
Diagnostic tests: Blood smear and bone marrow aspiration
Diagnosis: Indolent Chronic Lymphocytic Leukemia

Access Instance 3: All information has been marked as error.
(Strikethrough is used only to indicate to the Tester and Vendor that the entire note was marked as error and does not prescribe how the EHR is to indicate it is error data)
Physical exam: Irregularly shaped, 3 cm ulcerated pigmented lesion located on left upper back and enlarged axillary lymph nodes
Chest x-ray: Irregular mass in the left upper lobe of the lung
Diagnosis: Malignant melanoma with possible metastasis to lymph nodes and the lung
TD170.314(f)(5) Cancer Case Information – Data Set # 2

Electronically Record Cancer Case Information

A user records three instances of cancer case information for the test patient(s).

**Record Instance 1:**
- Physical exam: Left lower quadrant tenderness
- Procedure performed: Needle biopsy of left ovary
- Diagnosis: Mucinous cystadenoma of the left ovary

**Record Instance 2:**
- Diagnosis: infiltrating duct carcinoma of right breast
- Procedures performed: Biopsy, lumpectomy
- Plan: Chemotherapy regimen of Cytoxan x 4 cycles

**Record Instance 3:**
- History: Breast cancer
- Reported symptoms: Severe back pain
- Diagnostic test: CT of lumbar spine
- Findings: Osteolytic lesion in the lumbar body L4 consistent with metastatic breast cancer

Electronically Change Cancer Case Information

A user changes the three instances of cancer case information recorded for the test patient(s).

**Change Instance 1:** Mark words as error and enter replacement words.
(Strike through is used only to indicate to the Tester and Vendor which words are error and does not prescribe how the EHR is to mark the words as error)
- Physical exam: **Left** Right lower quadrant tenderness
- Procedure performed: Needle biopsy of **left** right ovary
- Diagnosis: Mucinous cystadenoma of the **left** right ovary

**Change Instance 2:** Add words to the Information
- Diagnosis: infiltrating duct carcinoma of right breast
- Procedures performed: Biopsy, lumpectomy, and sentinel lymph node surgery
- Plan: Chemotherapy regimen of Adriamycin and Cytoxan x 4 cycles

**Change Instance 3:** Cancer case information was entered into the wrong patient’s record. Mark all information as entered in error.
(Strike through is used only to indicate to the Tester and Vendor that the entire note is to be marked as error and does not prescribe how the EHR is to mark the note as error)
History: Breast cancer
Reported symptoms: Severe back pain
Diagnostic test: CT of lumbar spine
Findings: Osteolytic lesion in the lumbar body L4 consistent with metastatic breast cancer

Electronically Access Cancer Case Information
A user accesses and displays the three instances of cancer case information that were recorded and changed.

Access Instance 1:
Physical exam: Right lower quadrant tenderness
Procedure performed: Needle biopsy of right ovary
Diagnosis: Mucinous cystadenoma of the right ovary

Access Instance 2:
Diagnosis: infiltrating duct carcinoma of right breast
Procedures performed: Biopsy, lumpectomy, and sentinel lymph node surgery
Plan: Chemotherapy regimen of Adriamycin and Cytoxan x 4 cycles

Access Instance 3: All information has been marked as error.
(Strikethrough is used only to indicate to the Tester and Vendor that the entire note was marked as error and does not prescribe how the EHR is to indicate it is error data)

TD170.314(f)(5) Cancer Case Information – Data Set # 3

Electronically Record Cancer Case Information
A user records three instances of cancer case information for the test patient(s).

Record Instance 1:
Symptoms: Blood in stool and intermittent constipation
Diagnostic test: Screening colonoscopy
Findings: Colon polyp
Diagnosis: One adenomatous polyp in the colon
Plan: Refer for surgical consultation

Record Instance 2:
Record Instance 3:
Diagnosis: Stage IIIB colon cancer
Treatment provided: External beam radiation
Plan: Continue external beam radiation for 6 weeks, then evaluate for boost modality therapy

Electronically Change Cancer Case Information
A user changes the three instances of cancer case information recorded for the test patient(s).

Change Instance 1: Mark words as error and enter replacement words. 
(Strikethrough is used only to indicate to the Tester and Vendor which words are error and does not prescribe how the EHR is to mark the words as error)
Symptoms: Blood in stool and intermittent chronic constipation
Diagnostic test: Screening colonoscopy
Findings: Colon polyp, polyps
Diagnosis: One adenomatous polyp, Multiple adenomatous polyps in the colon
Plan: Refer for surgical consultation

Change Instance 2: Add words to the Information
Diagnosis: Stage 4 malignant melanoma of the right back
Treatment provided: High-dose interferon-2
Plan: Referral to a surgical oncologist for resection

Change Instance 3: Cancer case information was entered into the wrong patient’s record. Mark all information as entered in error.
(Strikethrough is used only to indicate to the Tester and Vendor that the entire note is to be marked as error and does not prescribe how the EHR is to mark the note as error)
Diagnosis: Stage IIIB colon cancer
Treatment provided: External beam radiation
Plan: Continue external beam radiation for 6 weeks, then evaluate for boost modality therapy

Electronically Access Cancer Case Information
A user accesses and displays the three instances of cancer case information that were recorded and changed.

Access Instance 1:
Symptoms: Blood in stool and chronic constipation
Diagnostic test: Screening colonoscopy
Findings: Colon polyps
Diagnosis: Multiple adenomatous polyps in the colon
Plan: Refer for surgical consultation

**Access Instance 2:**
Diagnosis: Stage 4 malignant melanoma of the right back
Treatment provided: High-dose interferon-2
Plan: Referral to a surgical oncologist for resection

**Access Instance 3:** All information has been marked as error.
*(Strikethrough is used only to indicate to the Tester and Vendor that the entire note was marked as error and does not prescribe how the EHR is to indicate it is error data)*
Diagnosis: Stage III B colon cancer
Treatment provided: External beam radiation
Plan: Continue external beam radiation for 6 weeks, then evaluate for boost modality therapy
## Document History

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<thead>
<tr>
<th>Version Number</th>
<th>Description of Change</th>
<th>Date Published</th>
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<tbody>
<tr>
<td>1.0</td>
<td>Released for public comment</td>
<td>November 19, 2012</td>
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<tr>
<td>1.1</td>
<td>Delivered for National Coordinator Approval</td>
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<td>1.2</td>
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